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Listening to Chekhov: Narrative Approaches to Depression

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We live in an era of depression. According to the World Health Organization, depression affects 121 million people across the globe; it is the fourth leading contributor to the global burden of disease and, by the year 2020, will be the second.¹ At its worst, depression leads to suicide, killing approximately 850,000 persons every year worldwide.² In the United States alone, the *Journal of the American Medical Association* reports, about 16 percent of the population, roughly 35 million people, suffer from severe depression in their lifetime.³ In any one period, 13 to 14 million Americans are thought to experience the illness.⁴

Numbers tell us the pervasiveness of depression; they do not tell us about the intensity of individual suffering. Andrew Solomon, in his memoir, *The Noonday Demon: An Atlas of Depression*, compares his experience of depression to that of a strong and dignified oak tree being persistently and maliciously attacked by a parasitic vine. Melancholia wrapped itself around him, ugly and sure, until his life was gradually asphyxiated: "I knew that the sun was rising and setting, but little of its light reached me. I felt myself sagging under what was much stronger than I."⁵ Solomon felt that the tendril of depression "threatened to pulverize my mind and my courage and my stomach, and crack my bones and desiccate my body. It went on glutting itself on me when there seemed nothing left to feed it."⁶ In this state of utter desperation, he believed that the melancholia was so intertwined with his life that any attempt to destroy the malignant vine would destroy his own self in the process. All he could do was helplessly wish that somehow he would die and be relieved of his misery.

Philosopher Julia Kristeva describes the experience of melancholia as an abyss of sorrow, a noncommunicable grief, that leaves its victims all but mute.⁷ Melancholia lays claim on its sufferers and sucks out

all of their interest in words, actions, and even life itself. The initial despair can be triggered by a setback in love or in life, perhaps a betrayal, an illness, or an accident, that wrests people away from what they know and expect. But when melancholia sinks in, people do not snap back; they are thrown into another life, one that is out of proportion with their setbacks. Kristeva describes this other life of depression as “unlivable, heavy with daily sorrows, tears held back or shed, a total despair, scorching at times then wan and empty. In short, a devitalized existence that, although occasionally fired by the effort I make to prolong it, is ready at any moment for a plunge into death.”⁸ Depression is “a living death, my flesh is wounded, bleeding, cadaverized, my rhythm slowed down or interrupted, time has been erased or bloated, absorbed into sorrow.”⁹ Kristeva likens depression to a “black sun” whose eerie, lethargic rays have the power to pin its victims down to the bed, to the ground, and leave them compelled to silence and renunciation.¹⁰

Despite the seriousness of depression today—both its pervasiveness and the extensive suffering it causes—this is an era that seems naïve and unsophisticated about the multiple dimensions of depression. The vast majority of clinical discourse embraces a biological model that describes depression as a medical disease involving neurological pathology. Using disease logics, like the commonly held notion of a “neurochemical imbalance,” the expected solution lies in pharmaceutical interventions.¹¹ Eli Lilly’s blockbuster medication Prozac provides a useful benchmark for how pervasive this solution has become. Between 1987 and 2002 (the year Prozac came off patent), new prescriptions for the drug reached over 27 million.¹² Combined with the multiple “me too” drugs it inspired—the class of antidepressants known as “selective serotonin reuptake inhibitors” (SSRI)—that total reached 67.5 million in the United States alone.¹³ These numbers suggest that almost one in four people in the United States began taking a Prozac-type drug between 1987 and 2002.

Simultaneous with this epidemic of prescriptions, there has been a significant public reaction that expresses serious doubts and even ardent criticism of all this brain manipulation. But neither the lingering doubts nor the vocal critics have had much effect on the current disease model of depression. The doubts are too abstract and too much like navel-gazing in the face of the tremendous suffering of depression. And the critics just seem to miss the point. They argue that the biological model is wrong because it is too simple, too reductionistic. But, judging by the number of SSRI prescriptions, people seem more

than willing to sacrifice a comprehensive understanding of depression if they can feel better.

Thus, in the face of its doubts and its critics, today's era of depression has cosmopolitan culture charging headlong into increasing brain science and brain interventions. But even as this happens, it is hard to escape the persistent feeling that we, as a culture, are missing something important. It is hard to escape the nagging suspicion that if we primarily study our brains, and primarily intervene by altering our neurotransmitters, we will become increasingly naïve about the meanings of depression at the same time that we are increasingly becoming victim to its incidence.

It is time to move beyond biological models of depression and the usual critiques of reductionism. We cannot embrace the dominant discourse of depression nor can we simply accuse biological models of being too reductionistic. We need a new approach to depression that recognizes the value of reductionistic biological models while at the same time putting these models into a greater perspective. What we need, and what I will argue for later in this paper, is a narrative approach to depression.

Turning to Chekhov

Developing an alternate frame for depression requires us to step back from contemporary clinical science and its critics, and there is no better place to start than with the work of Anton Chekhov, which offers the combined wisdom of a writer, a physician, and a man who likely went through the depths of depression himself. As a writer, Chekhov is a deep and rare genius of the ordinary and the everyday. His stories and plays, often of sadness and woe, give European literature a subtle and richly ambiguous world of psychological, moral, and social contemplation. Since Chekhov was also a physician, he approaches these tales not only with the eye of a literary master but also with the experiences of his medical science training and his life of clinical encounters. Chekhov was as devoted to medicine as he was consumed by literature. Shortly after medical school, he traveled over eight hundred kilometers across Siberia to study the harsh medical conditions of an infamous penal colony. When he returned, he set up and maintained a general medical practice, kept meticulous records, and at one time was appointed district public health officer during a raging cholera epidemic. Chekhov acknowledges in an autobiographical

statement that he persistently used his medical training in his creative work: "My knowledge of natural sciences and scientific methods has made me careful and I have always tried, when possible, to take into consideration the scientific data [when I write]."14

In addition to his extraordinary skills in literature and medicine, Chekhov, biographers suspect, suffered periods of depression: despair, loss of confidence, and loss of pleasure in his life. Chekhov therefore also brings to his work firsthand experiences of depression. His worst suffering came just after his brother, Kolia, died of tuberculosis when Chekhov was a young man. But the echoes and permutations of this sadness run throughout Chekhov's life. Much of it may have revolved around his premonitions of death. Like his brother, Chekhov died young from tuberculosis (at the age of forty-four). His first bout of hemoptysis occurred in 1884, the year he graduated from medical school, and this blood-spitting recurred regularly each year. Although Chekhov did not speak publicly of the disease until near the very end, he must have known fairly early on that he was dying from consumption. In all likelihood, both the sadness and the wisdom that pervade Chekhov's life and work are connected to his awareness of death and his intimations of mortality.¹⁵

Chekhov's writings contain many portrayals of depression and psychic distress. For example, in the short story "The Fit," a law student relapses into depression after witnessing the exploitation and cruelty of brothel life. The play *Uncle Vanya* portrays the chronic despair of its protagonist, Vanya. In "A Doctor's Visit," a young girl falls into a state of anxiety, weeping, and sobbing related to the desolation of her surroundings. "Ward Number 6" tells the story of a medical superintendent's decline and eventual admission into his own psychiatric asylum. And in "The Black Monk," Chekhov depicts the strange hallucinations and despair of Kovrin, a young philosophy student who is fatally ill with tuberculosis.¹⁶

But Chekhov's most concentrated study of depression comes from his early play *Ivanov*, in which the lead character, Nikolai Ivanov, suffers from a deep and profound sadness. The play reads very much like a psychiatric case study. Dr. Chekhov presents Ivanov's difficulties with the reflective empathy of a master clinician and the subtlety of a great writer. He does not romanticize Ivanov's troubles (indeed far from it), nor does he force his interpretation into a single pathological frame. Chekhov presents Ivanov with all the simplicity and complexity that realistic fiction requires. This approach to "the case" of Ivanov is exemplary in the study of psychiatry because, all too often, psychiatric

case studies come to us in a predetermined explanatory frame. Chekhov resists this temptation, and, as a result, his case study of *Ivanov* is an extremely useful guide for us today.

Ivanov's situation can be summarized as follows: He is a thirty-five-year-old married Russian landowner who has been in excellent health all his life. But, over the past two years, he has gradually sunk into increasing sorrow and despair. He struggles with unshakable feelings of melancholy and even suicidal preoccupations that are so severe that, by the play's end, he takes his own life.

The question that runs throughout Chekhov's play is perhaps the most obvious one: How should the events leading up to *Ivanov's* death by self-inflicted gunshot wound be understood? What, in short, is wrong with *Ivanov*? Although the question may be straightforward, the subtleties of Chekhov's answers are anything but, and these subtleties are particularly difficult for contemporary audiences to apprehend. Thanks to the tremendous hype surrounding today's medical models of mental suffering, modern audiences are likely to interpret *Ivanov* as biologically/neurologically depressed.

Consider, for example, what happened when psychiatrist Peter Kramer, the author of the 1990s best-seller *Listening to Prozac*, went to a production of the play at the Lincoln Center. From his *New York Times* review, it is clear that Kramer listened to *Ivanov's* troubles and heard a straightforward case of clinical, or medical model, depression.¹⁷ Kramer finds *Ivanov* to be a veritable catalog of diagnostic signs and symptoms. He is persistently sad, irritable, and bored with life. He has marked feelings of guilt and worthlessness, inability to sleep, lack of appetite, and lack of sexual desire for his wife. In addition, *Ivanov* is severely suicidal. For Kramer, *Ivanov* has all the key symptoms that, according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), 4th edition, indicate a "Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features—diagnostic code 296.23."¹⁸

Not only does Kramer see *Ivanov* as clinically, or biologically, depressed, but he also makes the claim that his own clinical ear, his way of listening to *Ivanov*, has become the current cultural dominant.¹⁹ For the "contemporary ear," Kramer argues, the play has been "sapped of any moral consequence."²⁰ Persistent sadness is a chemical imbalance, and "[s]uicide is part of the disease. . . . Suicide is what the death certificate says when one dies of depression."²¹ End of analysis. Clearly, Kramer feels there is no need for further interpretation—except perhaps to seek out *Ivanov's* genetic flaws and biological predispositions. There

is no need to ask, “What is Ivanov so depressed about?” or “What does Ivanov’s suffering mean in a larger frame?” For Kramer, whatever the reasons for Ivanov’s sadness, they are insufficient to account for his clinical depression. As the title of his review makes clear, what Ivanov needs today is an antidepressant.²²

But Kramer’s confident biological reading—useful as it may be in some circumstances—misses exactly what is most interesting about *Ivanov*. He gives no historical or political context and disregards entirely the fact that *Ivanov* is set in a time of great upheaval and social malaise in Russia: the generation before the 1917 revolution, a period Donald Rayfield calls “one of the richest and most contradictory periods in Russia’s political and cultural history.”²³ And, even more importantly, Kramer ignores how the play centers not so much on Ivanov himself but on the whole question of interpreting and categorizing humans. As drama critic Richard Gilman asserts, the central point of the play “isn’t Ivanov’s behavior in itself but the range of reactions to it and, by extension, the whole question of how much we can know about ourselves and other people.”²⁴

What is most fascinating about *Ivanov* is that almost every character has an opinion about Ivanov’s problems, and throughout the play they offer diverse, wildly incommensurable interpretations of Ivanov. As Chekhov states in a letter to his brother, the play’s originality comes not from its subject matter but from his own refusal to take an authorial position on the meaning of the play: “I have not introduced a single villain or a single angel (though I have not been able to abstain from fools): nor have I accused or vindicated anyone.”²⁵

Thus, another understanding of Chekhov’s play is that it is not about medical depression at all but, rather, the indeterminacy of interpretation. On this reading, *Ivanov* takes its place alongside Dostoevsky’s work as an example of what Mikhail Bakhtin calls polyphonic fiction. For Bakhtin, the many voices and simultaneous points of view contained within Dostoevsky’s fiction creates a “polyphonic world” that destroys “the established forms of the . . . *monologic* (homophonic) European novel.”²⁶ In a similar vein, Chekhov’s polyphonic portrayal of Ivanov does not present an omniscient point of view, nor does it privilege any particular character’s interpretation of Ivanov. Chekhov structures the play to highlight the multiplicity of meaning and the possibility of respecting the interpretive diversity of the characters. Looking more closely at the play’s many perspectives on Ivanov, we get a clearer sense of what this might mean.

First, there is Borkin, the estate steward, who interprets Ivanov not as constitutionally depressed but as a “whining neurotic.”²⁷ Borkin believes Ivanov should drop all his melancholy talk, grow up, and start making some money. After all, Borkin exclaims to Ivanov, “you’re not a schoolboy” anymore (3.8.29). By contrast, another character, Zinaida, Ivanov’s best friend’s wife, formulates Ivanov’s sadness in a very different way: “Can you wonder darling? [Sighs] The poor man made a ghastly mistake—marrying that wretched Jewess and thinking her parents would cough up a whacking great dowry. It didn’t come off. When she changed her religion they cut her off and cursed her, not a penny did he get. He’s sorry now it’s too late” (2.3.29–33). For Zinaida, Ivanov’s sadness is the result of profound regret and lost expectation. From her perspective, Ivanov ruthlessly manipulated his wife for a dowry he never received and he organized his life around that cold calculation. As a result, his regret is his just reward: his moral payback for treating his wife so callously.

Sasha, a young woman in the village, is in love with Ivanov and sees his plight very differently again. Sasha understands the problem to be not that Ivanov is callous and manipulative but that he is too kind and generous for his own good: “Ivanov’s only fault is being weak and not having enough go in him to chuck out . . . Borkin. . . . He’s been robbed and fleeced left, right and center—anyone who liked has made a packet out of Ivanov’s idealistic plans” (2.3.78–82). Furthermore, Sasha sees Ivanov as lonely and forlorn. He has fallen out of love with his wife, through no fault of his own, but he hasn’t the heart to break off the marriage. Sasha even has a treatment recommendation. “I understand you,” she tells Ivanov. “You’re unhappy because you’re lonely. You need someone near you that you love and who’ll appreciate you. Only love can make a new man of you” (2.4.14–16).

Anna, Ivanov’s wife, agrees with none of these interpretations. Instead, she has a cathartic theory of Ivanov’s troubles. For Anna, the problem is that Ivanov has failed to properly grieve for his many life disappointments. In other words, Ivanov needs to go through the work of mourning and come through to another side. This process, which psychoanalyst George Pollock calls “mourning-liberation,” would allow Ivanov to heal through a proverbial welling up with tears.²⁸ As Anna puts it, Ivanov should spend time alone with her in the dark clarity of night: “[Y]ou can tell me all about how depressed you are. Your eyes are so full of suffering. I’ll look into them and cry, and we’ll both feel better” (1.4.55–7).

But Lyebedeve, Ivanov's best friend, sees things very differently. Lyebedeve puts Ivanov's despair in a social-historical context: "I don't know, old man. It did look to me as though your various troubles had got you down, but then I know you are not one to—it's not like you to knuckle under. . . . You know what? It's your environment that has got you down" (3.5. 88–90, 97–8). Lyebedeve believes that Ivanov's sadness comes from his social surroundings, which represent and are symptomatic of a broader cultural malaise, or what contemporary philosopher Susan Bordo calls a "crystallization of culture."²⁹ Bordo uses this phrase to go beyond the most liberal of clinical biopsychosocial formulations. The issue is not simply that psychiatric conditions have cultural expression and a social context. They do, of course. But, for Bordo, psychopathologies must not only be culturally contextualized, they must also be understood as symptomatic articulations of deep cultural tensions and power imbalances. Psychopathologies, far from being anomalies or aberrations, are "characteristic expressions" of the cultural fault lines in which they develop.³⁰ They signal and crystallize much of what is wrong with the culture of their formation.

While Ivanov the character quickly rejects an environmental theory, *Ivanov* the play does not. Throughout, as in most of Chekov's plays, there is a detailed description of the wane of the landed class, the rise of the business class, and the stale paralysis and anomie with which the gentry respond to it all. Indeed, in *Ivanov* it is not just Ivanov who is affected; many of the characters complain of boredom, lack of energy, and loss of pleasure. At a party, for example, we hear characters say, "Lord I'm bored stiff" (2.1.42), or "Don't you ever get tired of sitting around like this? The very air's stiff with boredom" (2.3.88–9). One guest even exclaims, "This is all such a crashing bore, I feel like a running dive into a brick wall. God, what people!" (2.9.5–6). The air of depression and gloom found in so many of the men in the community provokes Sasha to exclaim, "There's something wrong with you all, and no mistake. The sight of you's enough to kill the flies or start the lamps smoking. Yes, there's something wrong—I've told you thousands of times and I'll go on telling you—something wrong with you all, wrong, wrong, wrong!" (2.3.103–7).³¹

But what does Ivanov have to say about his sadness? It turns out that even he feels conflicted about how to understand the depression he suffers. Sometimes Ivanov reduces his troubles to laziness and weakness of the will: "Laziness is laziness," he tells Sasha, "weakness is weakness—I can't find any other name for them" (4.8.68). In a soliloquy, he continues in this vein by calling himself a "nasty, miserable nobody"

(3.4.1). But, in talking to his friend Lyebedev, he works out an alternate, and very detailed, formulation of what in contemporary United States culture we might call “burnout” or “midlife crisis.” Ivanov explains that he was full of energy and enthusiasm in his youth: “I believed in different things from other people, married a different sort of wife, got excited, took risks . . . and was happier and unhappier than anyone else in the country” (3.5.98–100). All that activity has overstrained him. As he explains, “Those things were my sacks, I heaved a load on my back and it cracked. At twenty we’re all heroes, tackle anything . . . but by thirty we’re tired and useless” (3.5.100–3).

But Ivanov is inconsistent with this explanation as well. At a later point in the play he tells Lyebedev, “I won’t try to explain myself—whether I’m decent or rotten, sane or mad. You wouldn’t understand” (4.10.1–3). In this interpretation, Ivanov’s perspective resembles Kramer’s medical model, and he presents himself as having something like a medical disease: “I’m quite ill,” he tells Yevgeni Lvov (the young village doctor). “I’m irritable, bad-tempered and rude . . . I’ve headaches for days on end, I can’t sleep, and my ears buzz . . . I’m so mixed up, I feel paralyzed, half dead or something . . . I don’t know myself what’s going on inside me” (1.3.55–6, 72, 88). At one point, he even says, “[M]y brain doesn’t obey me, nor my arms or legs,” and he falls into weeping (3.4.13–14). Here, Ivanov sees his sadness as having no meaning, as being outside any human integrative frame—except of course the interpretive frame of bodies, brains, and medical science. From this biological model, Ivanov’s depression comes out of the blue and exists at the status of pathophysiology, much like a heart attack or an idiopathic seizure.

Despite all the ambiguity within the play, there is one character, Dr. Lvov, who stands apart in his adamant certainty of his opinion about Ivanov’s melancholia. It is with this character that Chekhov portrays, with full force, his negative authorial judgment: Lvov is the “the fool” Chekhov could not resist including. Lvov imagines himself to be an earnest, high-minded, dedicated physician with an intense social conscience. But the play’s other characters do not see him, or his profession, in the same light. As one character says, “Doctors are like lawyers, only lawyers just rob you, while doctors rob you and murder you too” (1.3.1–3). Lvov comes across to many of the characters as priggish and self-righteous. “Oh, he’s virtue incarnate,” someone says mockingly of him, “can’t ask for a glass of water or light a cigarette without displaying his remarkable integrity” (2.4.85–8).

Lvov's perspective on Ivanov turns out to be the harshest and most pathological of the play. Lvov finds Ivanov's melancholia and his related disinterest in his wife detestable. He labels Ivanov "insensitive, selfish, cold . . . heartless" (1.5.22) and an "unmitigated swine" (4.10.40–1). Lvov tells Ivanov that Anna "who loves you is dying . . . she hasn't long to life, while you—you are so callous . . . I do most thoroughly dislike you" (1.5.23–7). Lvov's scorn is at first met by Ivanov with weary admissions of blame and appreciation for Lvov's seemingly neutral concern. Within the context of the play, however, Lvov's neutrality is much less clear. There is constant tension around whether Lvov is in love with Anna and whether his interpretations of Ivanov are merely self-serving attempts to win Anna's affections.

Whatever Lvov's motivations, the more he presses his perspective, the more Ivanov loses patience with him. In one of the climactic scenes of the play, Ivanov exclaims to Lvov in exasperation:

Think a little, my clever friend. You think I'm an open book, don't you? I married Anna for her fortune, I didn't get it, and having slipped up then, I'm now getting rid of her so I can marry someone else and get *her* money. Right? How simple and straightforward. Man's such a simple, uncomplicated mechanism. No, doctor, we all have too many wheels, screws and valves to judge each other on first impressions or on one or two pointers. I don't understand you, you don't understand me and we don't understand ourselves. A man can be a very good doctor without having any idea what people are really like. So don't be too cocksure. (3.6.72–81, Chekhov's italics)

From my perspective, Ivanov's advice to Lvov is appropriate for the contemporary psychiatric community as well. The problem with Lvov's interpretation is not that it is wrong in any simple way. Ivanov does not actually dispute the content of Lvov's claims, only his dogmatic certainty. Lvov picks out elements of Ivanov's story and arranges them together into a plausible whole. This is also true for medical model interpretations like Kramer's. The play does contain data that supports medical model perspectives so the problem is not the perspective but rather the dogmatism. The problem is the cocksure self-confidence of Lvov and Kramer's attitude.³²

Such confidence is blind to the possibility of multiple interpretations and it narrows meaning down to a single option. Dr. Chekhov counters Dr. Lvov's certainty with the challenge of a polyphonic world and with the multiplicities of consciousness and experience. Dr. Chek-

hov challenges Dr. Lvov to appreciate the possibilities of interpretative diversity. His message is equally imperative for today's biopsychiatry. If biopsychiatry listened more closely to *Ivanov* the play, rather than narrowly reading *Ivanov* the character, it would throw its DSM-led interpretations (and its drive for antidepressant "cures") into the ring with a myriad of other interpretations. It would not foreclose other, equally vital understandings of melancholia and suffering.³³

Reframing Depression: A Narrative Approach

With Chekhov's work in mind, we can recognize the need for an approach to depression that includes our current biological model (albeit, in a more humble form) but that refines this model. Single-minded biological models of depression are not enough. But what alternate model is Chekhov using? He does not tell us. *Ivanov* is not an expository treatise on depression, or a theory of depression; it is an imaginatively created case history. Chekhov leaves it up to the reader to put this case study into an interpretive frame. I will now argue that Chekhov's model, or frame, for depression can best be understood as a narrative one.

Chekhov's narrative frame for depression likely emerged from his personal experience of combining medicine and literature. Chekhov famously describes the relationship between his two occupations in this way: "Medicine is my lawful wedded wife, and literature my mistress. When one gets on my nerves, I spend the night with the other. This may be somewhat disorganized, but then again it's not as boring, and anyway, neither one loses anything by my duplicity."³⁴ Chekhov uses this unfortunately sexist imagery to evoke his lived experience of moving back and forth between the two positions of medicine and writing. It was through this constant movement, I believe, that Chekhov broke out of the standard frame of most medical writing and research.

Chekhov's dual positions of doctor and writer produced diametrically opposed relationships to the role of narrative frame in representation. In his occupation as a doctor, Chekhov's task was to background narrative frame and to view his patients from a positivist model of objectivity. But this positivist stance (which continues to subtend medicine today) was not Chekhov's only position. As a writer, he worked from an opposite position that foregrounds narrative frame. In other words, he inhabited a practice that highlights the impossibility of telling a story without a point of view.

Contemporary physician-writer Abraham Verghese articulates this dual position in his discussion "The Physician as Storyteller." Speaking to fellow physicians at the American College of Physicians, Verghese explains that "[a]s physicians, most of us become involved in the stories of our patient's lives . . . we become players in these stories. Our actions change the narrative trajectory . . . and our patient's stories come to depend heavily on repetition of what we say."³⁵ Verghese argues that the inescapable thesis for medicine is threefold: "1.) *story* helps us link and make sense of events in our lives; 2.) we as physicians *create* stories as often as we record them . . . ; and 3.) we are characters in [these] various stories, walking on and off the stage in tales that take place in our hospitals and clinics" (1012, Verghese's italics).

Verghese points to examples by which physicians can reach this narrative awareness through years of attentive practice, but he argues that the more direct route is through combining the practice of medicine with the narrative tools that the writer possesses, or what Verghese calls the "storytelling craft" (1013). He explains that during his own initial immersion in the writing process he read closely and widely about the craft of writing. He found that the pillars of writing invariably involved the author's selection and organization of *story*, *character*, and *metaphor*. For Verghese, making these selections are "fundamental to good writing in the same way that internal medicine skills rest on understanding the mechanisms behind dyspnea, edema, polyuria and other cardinal manifestations of disease" (1014).

Verghese is not alone in these insights. They are, in fact, the core insights of medical humanities and of what Rita Charon rightly calls the "emerging field of narrative medicine."³⁶ A growing number of people in the medical field have come to appreciate that a knowledge base consisting primarily of the sciences is incomplete. As such, medicine is reaching out to the humanities to better understand and cope with illness and suffering. Literature and narrative studies are key in this.³⁷ As Charon puts it, when medicine is practiced with "narrative competence," health-care professionals enter the clinical situation with a nuanced capacity for "attentive listening . . . , adopting alien perspectives, following the narrative thread of the story of another, being curious about other peoples' motives and experiences, and tolerating the uncertainty of stories."³⁸

Narrative medicine advocates argue that clinicians "*need rigorous and disciplined training*" in narrative reading and writing not just for the clinicians' own sake (helping them to navigate the trauma and stress of clinical work) but also "*for the sake of their practice.*"³⁹ Without

narrative competence, clinicians have little chance of understanding and interpreting their clients' experiences of illness, and they have even less hope of understanding the narrative dimensions of their own disease models. For those in narrative medicine, narrative studies is not a mere flourish or an embellishment to the practitioner's knowledge base, it is indeed a "basic science" of medical practice.⁴⁰

Chekhov's combination of the storytelling craft and medical practice seems to have brought him to a position similar to narrative medicine. For scholars of narrative medicine, physicians are not just transparent recorders of disease. Similarly, when Chekhov includes physicians in his plays and short stories, they are hardly the voice of transparent objectivity. They represent one voice among many, one story among an array of stories. They may well be important to the plot, but they are hardly the positivistic truth.⁴¹ As Verghese puts it, physicians are "storytellers, storymakers, and players in the greatest drama of all: the story of our patients' lives as well as our own" (1016).

Kathryn Montgomery Hunter, in her important book *Doctors' Stories: The Narrative Structure of Medical Knowledge*, echoes this same sentiment: "[N]arrative of any length and fullness or speculative force inevitably pulls against medicine's commitment to objective scientific study of human illness."⁴² In making the case for a narrative approach to medicine, Hunter explains that what is needed is a means of moving away from the illusion "of objectivist, scientific reportage" and toward an acknowledgement that medical case histories are "humanly constructed" accounts: "Two things are essential: first, both tellers and listeners must recognize the narrator of the case history as contextually conditioned, and, second, the lived experience of the patient must be acknowledged."⁴³

Narrative medicine's emphasis on the contextually conditioned nature of knowledge, even medical knowledge, inevitably creates some ambiguity of interpretation. Though some might find this ambiguity troubling, Chekhov seems to revel in it.⁴⁴ Indeed, literary critic Karl Kramer refers to the frequent interpretive uncertainty in Chekhov's work as his "stories of ambiguity."⁴⁵ Kramer's reading of Chekhov finds unresolved paradox structured into many of his stories. Through a study of subsequent drafts of Chekhov's work, Kramer argues that Chekhov often deliberately reworks a story so that it cannot be read through a simple monologic lens. The ambiguity comes from the way Chekhov sets up contradictory readings from parallel passages throughout a given story. The result is a story that can be interpreted in several different ways. Although one interpretation may appear more

plausible than another, which often happens, no single reading will adequately account for the whole fabric of these stories. As Kramer puts it, that in and of itself “is sufficient to establish [Chekhov’s stories of] ambiguity.”⁴⁶

This reading of Chekhov’s writing fits perfectly with *Ivanov*. Throughout the play, as we saw earlier, each of the characters offers different narrations of Ivanov’s sadness. From a perspective of multiple and ambiguous interpretations, the question to ask is not simply, which story is true? but, instead, what are the consequences of each story? and what kind of life will follow from inhabiting these stories? Even if there is no essential or singular essence to Ivanov’s sadness, Ivanov arguably needs a story for his sadness. He can only crystallize a provisional subjectivity around his sadness through inhabiting a story and, to borrow a phrase from Freud, “working-through” the implications of that story.⁴⁷

From Antireductionism to Narrative Multiplicity

Although narrative medicine has had only limited applications in contemporary psychiatry, narrative approaches are extremely useful in moving beyond biological models and their critiques.⁴⁸ Recent scholarly work that is critical of today’s biopsychiatry rejects its simplicity. Critical scholars repeatedly scold reductionist approaches to psychiatry, like the one Peter Kramer performs in his reading of *Ivanov*, for denying the complexity of human life. These critics argue that scientific reductionism applied to psychiatry absurdly idealizes scientific method as a value-free mirror of the truth. This idealization ignores the desires and interests of psychiatric researchers, and, even more, it ignores the social, political, and economic contexts in which the researchers work.

This critique of simplicity and reductionism is an important first step in moving beyond the limitations of biopsychiatry. It is important to say that simplifications reduce complex reality to whatever fits into a simple scheme. It is also important to remember that reductions “forget” about the complex, which means that the complex is often surprising and disturbing when it inevitably reappears. However, it is equally important to be suspicious of the denunciations of simplicity, particularly denunciations that are overly reliant on the polemic trope of violence. Repeatedly, critics of simplicity argue that using single orders to tame complex realities exerts a reductionist “violence” on the real.

Versions of this argumentative style show up in popular critiques of biopsychiatry, such as Peter Breggin's *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry"* (1991), Elliot Valenstein's *Blaming the Brain: The Truth about Drugs and Mental Health* (1998), Paula Caplan's *They Say You Are Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal* (1995), and Seth Farber's *Madness, Heresy, and the Rumor of Angels: The Revolt against the Mental Health System* (1993). It also appears in the more subtle work of philosopher of psychiatry Edwin Wallace. In Wallace's critique of psychiatry's diagnostic manual, he (like almost everyone who seriously evaluates the DSM) chides the manual for its oversimplified "claim to atheoreticism."⁴⁹ Wallace argues that psychiatry's relentless pursuit of atheoretical simplification flies in the face of the twentieth century's "most respected philosophers of science," who have all held that idealized theoretical neutrality is a logical and empirical impossibility (81). As Wallace points out, it is not merely scientific assumptions and theories that we cannot escape, it is also "social, political, and moral philosophical ones as well" (81). Any attempt to avoid these complications, Wallace argues, does "violence to large arcs of the person and ignore[s] or deride[s] theoretical purviews and therapeutic modalities that can be necessary or lifesaving" (85).

When the critique of simplicity is shaped in this way, simplicity is doubly damned. Promoters of complexity argue that simplicity is not only wrong (out of touch with the real) but also inherently bad because violence is inherently bad. Clearly, given the power and pervasiveness of reductionism in the modern world, complexity is surely in need of some defenders. Yet this celebration of complexity is not the lesson we should draw from our reading of Chekhov. Deriding the violence of simplicity has become too easy, too simple, too disturbingly agreeable and self-satisfying. It has become a morally comfortable place to be, and it leaves a great deal to discover and articulate beyond the trope of violence. As science studies scholars Annemarie Mol and John Law assert, "We need other ways of relating to complexity, other ways for complexity to be accepted, produced, or performed."⁵⁰

The difference between Chekhov's narrative approach and that of the standard violence trope is that Chekhov values complexity without denigrating simplicity. In *Ivanov*, Chekhov respects rather than denounces the characters' oversimplifications of Ivanov. Chekhov resists, in other words, a normative view of simplicity. He helps us see a world where alternative (and inevitably simple) interpretations are not so much wrong or bad, but different. Chekhov does not denigrate the

characters' reduction of Ivanov's sadness into simple formulas. Each character presents seemingly viable interpretive options. Lvov comes under the most criticism, but, as I mentioned earlier, this comes from his dogmatism, not from the potential viability of his interpretations.

How can we scaffold a position that recognizes the limitations of simplicity without simultaneously giving normative preference to complexity? How can we articulate the value of both simplicity and complexity? We can begin by recognizing that simple reductions become less demonic when we multiply them. Moving from a single order to multiple orders, from a necessary order to a variety of orders, undermines the dichotomy between simple and complex. In a narrative medicine frame, this is where the trope of violence gives way to the trope of narrative multiplicity. Multiplicities of metaphors, characters, and styles—not to mention multiplicities of logics, perspectives, paradigms, and discourses—hold in tension both the values of simplicity and those of complexity. Narrative multiplicity recognizes that each simplicity necessarily fails to capture complexity. Each simplicity selects and organizes highly idiosyncratic cuts from the data. Each simplicity, in other words, is necessarily limited. These limited, unavoidably simplistic perspectives, however, are less of a problem when they multiply. When simplicity multiplies, rather than becoming hegemonic, it becomes one of many. Through multiplication, each simplicity loses the violence of totalitarian control.

Moreover, narrative multiplicity sidesteps the usual modernist dichotomy of realism versus relativism. It allows us to develop a flexible ontology of "semiotic realism" and an epistemology of "pluridimensional consequences."⁵¹ By an ontology of semiotic realism, I mean to suggest that there is a real world out there that grounds our ideas and that our ideas are in touch with. However, the specific points of contact are determined by the semiotic relations from which our ideas are structured. These semiotic relations are relative to given narrative communities and traditions of thought. Semiotic realism rejects rigid ontologies of realism and relativism because it contains insights from both. Semiotic realism understands that knowledge articulations are grounded in the real world, but how and why they are grounded remains relative to a diverse multiplicity of narrative communities.

The related epistemology of pluridimensional consequences combines the French post-structural insights with that of the American pragmatists. Roland Barthes uses the term "pluri-dimensional order" to articulate the way that specific languages always remain too limited to capture the world in total.⁵² Despite this limitation, all linguistic commu-

nities do evoke, engage, and negotiate the world through some element of grounding or contact. Languages do not fully mirror or correspond to the world in all of the world's complexity, but languages do make real connections with the world. For the American pragmatists, different connections with the world yield different *consequences* for practice and for lived experience. From this perspective, the best knowledge is that which leads to the best consequences in practice.⁵³

When we apply these philosophic aspects of narrative multiplicity to psychiatry and depression, new forms of freedom and flexibility emerge. Narrative multiplicity hardly embraces an "anything goes" relativity, but it does create a conceptual structure where ontological questions (e.g., What are the core features of psychic life?) and epistemological questions (e.g., What is the best method to study people?) are not fixed in advance. Different answers may emerge, depending on related ethical questions (e.g., What kind of people do we want to be? and What kind of life worlds do we want to create?). Different understandings of the core features of people and different methods of inquiry about people yield very different kinds of people and very different kinds of life experiences. There are, in other words, multiple ways to organize human life. Making judgments between these different ways largely depends on the consequences and desired values. In short, there are multiple paths to wisdom and a meaningful life.

Narrative Psychiatry and Depression: Moving through the Looking Glass

These insights into Chekhov's model of depression bring me to my final point. Understanding Chekhov's narrative approach has real purchase when we move from the "free play" of fiction to the supposedly "hard facts" of psychiatric research. Listening to Chekhov allows us to make sense of perhaps the most important empirical psychiatric finding to date—the finding that alternative approaches to psychotherapy are *equally effective*. This is known lovingly in the therapeutic research community as the "Dodo effect." The appellation, first coined by Saul Rosenzweig, comes from a line in *Alice in Wonderland*: "At last, Dodo said, everyone has won and all must have prizes."⁵⁴

Although this finding is controversial and has been minimally integrated into clinical practice, empirical studies confirm with remarkable consistency that the positive effects of therapy (of which there are many) are not due to the specific interventions of the therapist.

The benefits of therapy come instead from “common factors” of the therapeutic setting.⁵⁵ That is, these studies suggest that the process of setting up a therapeutic relationship with a quality therapist is much more important than the content of the specific models and theories from which the therapist works.

In the case of depression, this seems to be just as true for biopsychiatric treatments as it is for other approaches. Meta-analysis reviews of SSRIs repeatedly show (1) that these medications do not have a clinically meaningful advantage over placebo, (2) that methodological problems likely account for the small differences that do occur, and (3) that this seems to be as true for severe depression as it is for milder forms.⁵⁶ The few studies that contrast effectiveness of psychotherapy with medications show that cognitive, behavioral, and interpersonal therapies all compare favorably with medications in the short term. And when long-term follow-up is considered, psychotherapy seems to be superior.⁵⁷ Although these studies are controversial and have their detractors, they are sufficiently substantial to seriously undermine any heavy-handed or necessary reading of depression as a biological disease. As one team of reviewers writes, “The silver lining in these results for psychiatry is that the psychiatrist, or at least something about the psychiatric relationship, and not the pill, appears to facilitate improvement in depression.”⁵⁸

The Dodo effect applied to depression means that a variety of theoretical models can be used to understand, to cope with, and to ameliorate the painful emotional states of depression. It does not mean that any old interpretation will do. Therapy does not work if the therapist says things completely out of context, such as “Your sadness is because the cow jumped over the moon.” On the contrary, for psychiatry to be effective in treating depression, the therapist and the client must have a sense of belief and confidence in the interpretive frame being used. In the words of Rosenzweig: “Whether the therapist talks in terms of psychoanalysis or Christian Science is . . . relatively unimportant as compared with the formal consistency with which the doctrine employed is adhered to, for by virtue of this consistency the patient receives a schema for achieving some sort and degree of personality organization.”⁵⁹

Applying these insights to Chekhov’s play suggests that an array of narrative approaches—each in their own way a simplification of possible interpretations—might be helpful for Ivanov. Any number of different interpretations of Ivanov could be developed and worked through in a therapeutic relationship with a quality, well-meaning prac-

tioner. If that were to happen, there is a very good chance that an array of different insights and narrative structures could effectively help Ivanov understand his sadness and provide him with tools for feeling better. If the insights and narrative frames were not imposed on Ivanov, but were ones that he participated in creating and whose meaning he felt strongly connected to, the therapy would work through encouraging modifications in Ivanov's assumptive worlds. These modifications would transform the meanings of his sadness to more favorable ones and free him up for alternative forms of coping.

As psychiatrist Jerome Frank states in the preface to *Persuasion and Healing: A Comparative Study of Psychotherapy*:

My position is not that technique is irrelevant to outcome. Rather, I maintain that . . . the success of all techniques depends on the patient's sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords, or can be brought into accord, with the patient's personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy.⁶⁰

Narrative approaches to depression, in this account, become a care and practice of the self. They become a way of bringing into being a certain kind of subjectivity. Multiple approaches to depression (including the biological model) may be helpful even if each approach necessarily simplifies and reduces the person's situation.

When we adopt Chekhov's narrative approach to depression, we move beyond biopsychiatry and its reductionist critiques. We recognize that simplification and reduction—even when they take the narrative frame of biopsychiatry—are not the problem. The problem is dogmatism and the refusal to appreciate an array of narrative simplifications. Accordingly, the goal is not to denigrate single solutions for their simplicity, nor is it to take single solutions and make them complex. The goal is to increase our appreciation of alternative solutions, be they simple or complex. The goal is openness to a range of options and to the richness and variety of psychiatric experience.

The implications of this narrative approach are many. Psychiatric practitioners will do well to heed the lessons of narrative medicine and

develop their own narrative competence. To do this, practitioners must understand the basics of narrative theory, and they must learn to read widely in a range of different contexts. They must come to appreciate the many stories of biopsychiatry, psychoanalysis, cognitive therapy, interpersonal therapy, family therapy, humanistic approaches, cross-cultural approaches, feminist approaches, disability activist approaches, postmodern approaches, spiritual approaches, and ecopsychology, to name a few. Furthermore, they must come to understand the value of biography, autobiography, and literature for developing a narrative repertoire. In the end, narrative competency for depression means a tremendous familiarity with the many possible stories of sadness. The more stories clinicians know, the more likely they are to help their clients find narrative frames that work for them.

For sufferers of sadness, a narrative understanding means that there is a range of possible therapies and healing solutions that might be helpful. An approach that is right for one person may not be right for another. There must be a fit between the person and the approach, and people should feel empowered to take seriously their own intuitions and feelings. If the person getting help does not feel this fit, he or she is likely right; there may well be another approach that would work better with the person's proclivities. Like everything else, however, judgment is critical. Therapeutic experiences of all kinds can be frustrating, slow, and uncertain. How, for example, does one know when an approach misses his or her needs and when it is something that will take time, patience, and perseverance to be helpful? From a narrative perspective, there can be no gold standard or simple answers. Only judgment, wisdom, and trial and error can decide.

NOTES

1. See World Health Organization, "Depression."
2. Ibid.
3. See Kessler et al., "The Epidemiology of Major Depressive Disorder," 3095.
4. Ibid.
5. Solomon, *The Noonday Demon*, 17.
6. Ibid.
7. See Kristeva, *Black Sun*, 3.
8. Kristeva, *Black Sun*, 4.
9. Ibid.
10. Ibid., 3.
11. Many argue that the "chemical imbalance model" of depression is a distortion of contemporary biopsychiatry. For example, see Lacasse and Leo, "Serotonin

and Depression," 2, 12. Even if we accept this argument, it does not change the underlying disease logics at the core of biological psychiatry. See Helen Mayberg's discussion of "limbic-cortical dysregulation" for an updated and sophisticated version of the neuropathology of depression (Mayberg, "Depression").

12. These numbers were calculated using drug sales data from IMS Health by Graham Aldred for the Alliance for Human Research Protection (AHRP). AHRP is a well-known citizens' watchdog organization that brings to public attention—through daily Infomails—human rights issues associated with biotech research and usage. For the details of Aldred's analysis, see Aldred, "An Analysis of the Use of Prozac, Paxil, and Zoloft in USA 1988–2002."

13. See Aldred, "An Analysis of the Use of Prozac, Paxil, and Zoloft in USA 1988–2002," 1.

14. Coulehan, introduction to *Chekhov's Doctors*, xiii. Additional helpful resources for understanding Chekhov's life and background include Chekhov, *A Life in Letters*; Chekhov, *Anton Chekhov's Life and Thought*; Rayfield, *Anton Chekhov*; Hingley, *A New Life of Anton Chekhov*; Finke, *Seeing Chekhov*; and Coope, *Doctor Chekhov*.

15. Because of the uniqueness of Chekhov's multiple positions, William Carlos Williams (also a master of literature and medicine) was correct when he told a young medical student looking for advice in understanding the subtleties of medicine to "[r]ead Chekhov, read story after story of his" (Coles, foreword to *Chekhov's Doctors*, xii). Contemporary physician Robert Norman says much the same thing when he tells fellow doctors, "I recommend you dive in [to Chekhov's writings] with abandon, soak up the visions of Chekhov, and you will emerge the better person" (Norman, "Literature and Medicine").

16. For a review of these portrayals from a medical perspective, see Coope, *Doctor Chekhov*, chap. 2.

17. See Kramer, "What Ivanov Needs in the 90's Is an Anti-Depressant."

18. *Diagnostic and Statistical Manual of Mental Disorders*, 347.

19. Although Kramer does not mention examples, it is certainly true that others in the medical humanities community interpret Ivanov in a similar way. Both Coope and Callahan also see Ivanov as clinically or biologically depressed. See Coope, 34–8; and Coulehan, "Ivanov."

20. Kramer, "What Ivanov Needs in the 90's is an Anti-Depressant."

21. *Ibid.*

22. For an extended version of this argument, see Kramer's recent book, *Against Depression*. Here, Kramer follows suit with his *Ivanov* review, using strategic polemic to claim that depression must be seen as a medical disease. He catalogs an array of contemporary scientific research that supposedly shows how depression disrupts brain functioning, damages the heart, and alters personal perspective. Kramer minimizes any complications of this interpretation to make the extreme claim that contemporary medical research demands that there be no alternative perspective on depression beyond a disease model.

23. Rayfield, *Anton Chekhov*, xvi.

24. Gilman, *Chekhov's Plays*, 67.

25. Hare, introduction to *Ivanov*, vii. See, also, Friedland, *Letters on the Short Story, the Drama, and Other Literary Topics, by Anton Chekhov*, 130.

26. Bakhtin, *The Bakhtin Reader*, 90 (Bakhtin's italics). For an excellent discussion of Bakhtin's concepts of "voice" and "polyphony" as applied to Chekhov and medicine, see Puustinen, "Voices to be Heard"; and Puustinen, "Bakhtin's Philosophy and Medical Practice." See, also, Cathy Popkin's discussion of Chekhov's frequent strategy of staging an incident and then providing two separate perspectives on it, "one that regards the incident as utterly trivial, barely worth mentioning, while the other discerns the maximal degree of catastrophe in the same event" (Popkin, *The Pragmatics of Insignificance*, 38).

27. Chekhov, *Ivanov*, 1.2.32. Subsequent references are cited parenthetically in the text with act, scene, and line numbers.

28. See Pollock, *The Mourning-Liberation Process*.

29. Bordo, *Unbearable Weight*, 139.

30. *Ibid.*, 141.

31. There is some evidence that Chekhov himself was not disposed to an environmental interpretation. Indeed, Chekhov explains in a letter that one of his early motivations for the play was to demolish all talk of Russia's superfluous men—the very *Ivanov* types that were so common in Russian literature at the time and who were generally understood to be suffering from a kind of social paralysis (see Chekhov, *A Life in Letters*, 175). Gilman argues, however, that Chekhov's motivations may have changed in the course of writing the play. Although he at first wished to dispose of environmental explanations for Russia's "superfluous men," during the process of writing the play "he steadily transformed it into something much richer and far less thematically local" (Gilman, 40). This interpretation would account for Chekhov's inclusion of general anomie in *Ivanov's* setting, and it would account for including Sasha's outburst that diagnoses all of the men in the area.

32. For a discussion of "dogmatism" in contemporary psychiatry, see Ghaemi, *The Concepts of Psychiatry*. Ghaemi concludes, based on an analysis of psychiatric practice, that approximately "64% of psychiatrists are dogmatists" (301).

33. For a discussion of DSM-led heavy-handedness in psychiatric interpretations, see Wood, "I Found Him!"

34. Chekhov, *Anton Chekhov's Life and Thought*, 107

35. Vergheze, "The Physician as Storyteller," 1012. Subsequent references are cited parenthetically in the text.

36. Charon, "Narrative Medicine: Attention, Representation, Affiliation," 261.

See, also, Charon, "Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust."

37. For a general discussion of medical humanities, see Campo, "The Medical Humanities"; Dittrich, "The Humanities and Medicine"; and Kirklin and Richardson, *Medical Humanities*. For a more specific discussion of literature and medicine, see Hawkins and McEntyre, *Teaching Literature and Medicine*; and Brody, *Stories of Sickness*.

38. Charon, "Narrative Medicine: Attention, Representation, Affiliation," 262. See, also, Holt, "Narrative Medicine and Negative Capability."

39. *Ibid.* (Charon's italics).

40. Charon, "Narrative and Medicine," 863.

41. For an excellent collection of Chekhov's portrayal of clinicians, see Coulehan, *Chekhov's Doctors*.

42. Hunter, *Doctors' Stories*, 166.

43. *Ibid.*

44. See Greenhalgh, "Narrative Based Medicine in an Evidenced Based World," for an attempt to reconcile the ambiguities of narrative medicine with the dictates of positivist medicine.

45. Kramer, "Stories of Ambiguity," 338.

46. *Ibid.*

47. See Freud, "Remembering, Repeating and Working-Through." Freud uses the phrase "working-through" to articulate the slow and often painful process of applying insight and meaning to the minutia of daily life. Using more contemporary theorists of subjectivity, this may also be seen as a kind of Foucauldian "technology of the self" (Foucault, "Technologies of the Self," 16). The "working-through" of the story is similar to what Michel Foucault means when he says that practices of the self are a kind of *askesis*, a form of training. It requires work and dedication to inhabit them. *Askesis*, Foucault summarizes, is "an exercise of self upon the self by which one tries to work out one's self and to attain a certain mode of being"

(Foucault, "The Ethics of Care for the Self as a Practice and Freedom," 2). This approach to subjectivity links well to other theoretical work in the humanities, such as Pierre Bourdieu's use of the term "habitus," Deleuze and Guattari's "becoming," and Judith Butler's "performativity." For further references and discussions of these theorists of subjectivity, see Mansfield, *Subjectivity*; Hall and Du Gay, *Questions of Cultural Identity*; and Du Gay et al., *Identity*.

48. For discussions of narrative psychiatry, see Martinez, "Narrative Understanding and Methods in Psychiatry and Behavioral Health"; and Roberts and Holmes, *Healing Stories*. For overviews of earlier uses of narrative theory in psychotherapy, see Freedman and Combs, *Narrative Therapy*; and White and Epston, *Narrative Means to Therapeutic Ends*.

49. Wallace, "Psychiatry and Its Nosology," 81. Subsequent references are cited parenthetically in the text.

50. Law and Mol, *Complexities*, 6.

51. For an extended discussion of these terms, see Lewis, *Moving Beyond Prozac, DSM, and the New Psychiatry*, 18–37.

52. Barthes, "Inaugural Lecture, College de France," 465.

53. For an additional discussion of pluralism and psychiatry, see Ghaemi, *The Concepts of Psychiatry*. Ghaemi's and my analyses are similar in that they both rely on the work of American pragmatic philosophy. They differ in that my work combines pragmatism with insights from literary theory and post-structuralism.

54. Lewis Carroll, *Alice in Wonderland and Through the Looking Glass* (New York: Bantam Books, 1981), 17, quoted in Rosenzweig, "Some Implicit Common Factors in Diverse Methods of Psychotherapy," 412. For extensive contemporary reviews of the Dodo effect, see Wampold, *The Great Psychotherapy Debate*; and Luborsky et al., "The Dodo Bird Verdict is Alive and Well—Mostly."

55. Wampold, *The Great Psychotherapy Debate*, 22.

56. See Kirsch et al., "The Emperor's New Drugs"; and Moncrieff and Kirsch, "Efficacy of Antidepressants in Adults."

57. See Antonuccio, Burns, and Danton, "Antidepressants."

58. Antonuccio, Burns, and Danton, "Antidepressants." For an alternate perspective, see Quitkin et al., "Validity of Clinical Trials of Antidepressants."

59. Rosenzweig, 413–15.

60. Frank and Frank, *Persuasion and Healing*, xv.

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